

The Medical Times and Register.

VOL. XXXIX No. 5.

PHILADELPHIA AND BOSTON, MAY, 1901.

WHOLE No. 1005

FRANK S. PARSONS, M. D., Editor.
DORCHESTER, BOSTON, MASS.

JOSEPH R. CLAUSEN, A. M., M. D., Manager.
1602 ARCH STREET, PHILADELPHIA, PA.

.....EDITORIAL STAFF.....

T. H. MANLEY, M. D., New York, N. Y.

J. J. MORRISSEY, A. M., M. D., New York, N. Y.

LOUIS FISCHER, M. D., New York, N. Y.

LEOPOLD F. W. HAAS, M. D., New York, N. Y.

J. A. TENNEY, M. D., Boston, Mass.

EDWARD A. TRACY, M. D., Boston, Mass.

H. B. SHEFFIELD, M. D., New York, N. Y.

A. J. DAVIDOW, M. D., Troy, N. Y.



BIMANUAL PALPATION OF THE PELVIC ORGANS.

By W. OAKLEY HERMANCE, M. D.,

INSTRUCTOR OF GYNECOLOGY, PHILADELPHIA POLYCLINIC,

Having considered in a brief article in THE TIMES AND REGISTER of April, the deportment of the physician toward his first gynecological patient and endeavored to point out a few facts of value, attention may now properly be turned to a brief resume of the important lessons to be learned from bimanual palpation of the female pelvis.

To reiterate an idea advanced in the former article; the young physician is rich in the text book knowledge of the size, shape and position of the genital organs, yet until he has had the experience of a number of vaginal examinations to form a fixed idea of the normal pelvis he has nothing with which to compare the pathological pelvis.

In attempting the description of a normal genital canal, uterus and adjacent organs, three important facts must be borne in mind. First, the normal healthy uterus is a movable

organ and assumes different positions with the movements of the possessor.

I have often noticed that in the progress of bimanual examination by a class of students, that the first member may find the fundus of the uterus leaning backward and the last may report the position well anterior, the organ having been moved through its normal arc of mobility by the efforts of the examining hands. Again, it is true that given a heavy uterus and a dorsal position of the patient the fundus will assume a more horizontal plane than when the woman is erect. Second, the size and shape of the uterus especially the cervical portion differ widely in different individuals. While one woman may possess normally a large uterus, another perhaps of the same weight and height and general appearance may be endowed with a small uterus, not poorly developed neither in any way pathological, but normally small. It has been my

experience that race presents some explanation for differences, for instance, the colored non-parturient woman has in the majority of instances an extremely long and conical cervix.

Third, after parturition either partus maturus or premature expulsion of the contents of the pregnant uterus, all conditions of the genital tract are completely changed and that which was normal to the individual before pregnancy though now vastly altered is still normal. The vaginal walls, the cervix and the vaginal outlet have all passed through a phenomena that has left an impression that nothing can efface.

Therefore, having given these important axioms due consideration it will be readily seen, that to accept one pelvis for a guide and from that to form opinions and conclusions would be fallacious reasoning and harmful teaching. It is only by taking into consideration the many influencing conditions set forth above, and creating an extemporaneous standard for each case under consideration, that pathological deductions can be correctly drawn.

Bimanual palpation should be made quickly; prolonged touch tires both the operator and the patient. Bimanual palpation should be made gently; force is a measure that will invariably defeat the object of the examination by arousing both conscious and unconscious resistance of the muscular portion of the abdominal wall. It is far better to allow the patient to leave the table with the diagnosis incomplete than to gain by undue force an erroneous opinion of the case, or what is equally discouraging to so maltreat the patient that she will refuse to return for further examination. Force is dangerous: I have seen

grave results from forcible and prolonged pressure. Pus tubes have been ruptured with the most serious consequences. A slightly less dangerous accident from this cause is the expulsion of a small amount of pus into the free abdominal cavity with acute pelvic peritonitis resulting.

It is often necessary to precede the bimanual examination by inspection of the vulva to ascertain the condition of Bartholin's glands, whether or not the hymen is intact, the state of urethral orifice whether inflamed or the seat of growth such as polyps or caruncles or whether bathed in infectious puss as in gonorrhœa.

There are three important positions in which to place the subject for examination: The left lateral or Sims posture, the knee chest posture and the dorsal posture. The first two are useful for visual examination of the vagina and the vaginal cervix but are not well adapted for bimanual palpation. Occasionally the standing and sitting or squatting postures are useful especially when there is any doubt as to the degree of relaxation of the vaginal walls or prolapse of the uterus. The last named or dorsal posture is the most generally useful position and best adapted for bimanual palpation. The process of bimanual palpation may be divided into three stages, the first or preliminary stage consisting of a vaginal examination with the left index finger and including the parts from the vaginal orifice to the vault. As the finger passes into the vagina notice of the following conditions should be taken; the state of the cutaneous perinium, the presence or absence of lacerations, the condition of the perinial body whether intact or ruptured and the state of the glands of Bartholin whether enlarged to the touch. The walls of the vagina are

noted as presenting the normal rugæ or smoothed out, the mucous surface harsh and dry or bathed in secretion. The sulci of the vagina should next be palpated and if lacerations exist ascertain the condition of the underlying muscle whether widely separated or not.

The finger now reaches the cervix and rapidly passing around its circumference the following points are noted; position in the vagina, low down upon the pelvic floor or tilted up toward the roof of the vagina, whether deflected to one side or the other. Its shape, conical or wedge-shaped, its size and its consistency, hard or soft. Whether in normal condition or lacerated and if lacerated the extent and nature of the laceration and degree of eversion of the anterior or posterior lips, not overlooking the presence or absence of fibrous nodules or enlarged follicles. The os, open or closed and if the seat of a polyp or a string of tenacious mucous.

The finger is now swept about the cervix and pressure made against the vaginal vault and the presence of pelvic masses noted their exact diagnosis being left to the future stages of the examination. Palpation of the rectum, which feels like a section of rope, and the presence or absence of contents, should not be forgotten neither should the careful touch of the urethral canal, the bladder and the ureters which may be made out to either side of the bladder.

The second stage consists of the combined method with the tips of the bended fingers of the right hand upon the hypogastrium and includes the examination of the body of the uterus, the whole object of this stage of the process is to grasp between the two hands the body of the uterus and elicit the following facts: the position

in the pelvis, its size, shape, consistency and most important whether freely mobile. This I would consider the most important feature in the entire examination as it is a dividing line in the classification of patients, in other words when the physician has learned to distinguish the fixed uterus he has learned the valuable lesson which experience has taught i. e. that the fixed uterus is a dangerous organ in the pelvis and must be treated with respect.

When the uterus is in a retroflexed position with the fundus in the cul-de-sac a rectal examination is a valuable adjunct, the anterior surface of the uterus being felt with startling distinctness, and in fact whenever there is any doubt as to a diagnosis, rectal examination will prove of great service.

The third stage in the bimanual method is the palpation of the adnexa, the ovaries fallopian tubes, the broad ligaments and the search for pathological growths in the pelvis. Starting with the fingers of the two hands surrounding the fundus palpation is made of the broad ligaments, the fallopian tubes and finally the ovary which if normal should appear about the size of the end of the thumb and should at once slip away from the examining fingers; failure to do this indicates abnormality. If careful touch fails to locate the ovary in its normal position, attention must be directed to the cul-de-sac of Douglas where a prolapsed organ will be found.

As to the significance of the various deviations from the normal, to attempt the suggestion and outline of all the evidences of disease that might be brought out by the variations from the normal condition of the genital organs would require a volume. It is of paramount importance for the inexperienced to acquire the ability to rec-

ognize an unaffected pelvis and to diagnose a fixed uterus. The recognition of tubal and ovarian enlargement, of myomata of the uterus and of ovarian cystoma is a further step in pelvic knowledge.

Subjective tenderness is an important symptom but does not always mean actual disease of the parts, as there is a well known class of patients who suffer pain upon pressure of uterus or ovaries without disease of these organs. This fact has been often proven by the persistence of the sensitiveness after removal of the organs.

Bimanual palpation should never be attempted in the presence of a loaded rectum. Alarming masses in the pelvis often disappear after a course of salines.

A thorough laxative should be given as routine treatment before any pelvic exploration.

Finally and emphatically the physician should not consider every pain in the abdominal or lumbar region caused by disease of the uterus and appendages. The tendency to-day, of the gynecologist is to wear the most opaque variety of blinders and to take for granted that every "female pain" is grist for his individual mill. There are many adjacent organs that can and do give rise to supposed pelvic symptoms and oftentimes it will be found that these symptoms will yield to attention and treatment of the gastro-intestinal tract and to the uric acid diathesis.

CONTINUED FEVER AS THE SOLE MANIFESTATION OF SYPHILIS TWENTY-FIVE YEARS AFTER A CHANCRE.

By M. ROCHEBLAVE.

Passing through an Italian city, I was asked to see a fellow-countryman whose health was seriously impaired. He was a married man 44 years of age, without children, originally robust, whose medical history spoke only of hydrocele, hygroma of the knee, and rheumatic pains, for which he had been sent, in September of 1897, to the saline and sulphureted springs of Acqui. He had a dry and stubborn cough, without physical signs to account for it; frequent headache, constipation, insomnia, mental and physical depression, all being attributed to neurasthenia.

Upon his return from Acqui the patient had fever, which was at first regarded as due to grippe and subsequently to malaria. He was given a gramme (15 grains) of quinine for forty days. The stomach then becoming intolerant, he was given twenty-one hypodermic injections of the same dose. Nevertheless,

no day passed without fever. After administration of the drug the temperature descended, indeed, to 37° C. (98.6° F.), or even lower, but at the end of a couple of hours it stood again at 38.5° C. (101.3° F.).

When M. Rocheblave saw him, the patient had the general aspect of chlorosis; but the most methodical examination revealed no alteration of the liver, spleen, heart, or lungs. The diagnosis of malaria was rejected on account of the curve of the temperature-chart, the integrity of the spleen and liver, and above all, the failure of the specific medicine. The hypothesis of beginning pulmonary tuberculosis was not entertained. "If the cough, the loss of strength and appetite might cause one to think of tuberculosis, the persistence of the fever notwithstanding rest in bed and the absence of any pulmonary lesion, for nothing more than a slight degree of

emphysema was detected by auscultation, would prevent one from forming such a diagnosis."

M. Rocheblave concluded that only syphilis could produce this continued fever without chills, without stages of sweating or heat, as high in the morning as the evening, never going above 39° C. (102° F.), rebellious to quinine sulphate and occurring in the person of a man who had never lived in a malarial country.

Interrogated upon this point, the patient confessed that he had contracted syphilis at the age of 19 and had had no more than seventeen days' treatment. Five years later his left testicle became very large and hard. A professor of the University of Siena called it a syphilitic testicle and first advised ten inunctions of mercurial ointment and subsequently pills of protiodide for ten days. During these twenty days the patient also took potassium iodide in the dose of one gramme the first day, 2 grammes the second day and then 3 grammes until the twentieth. He was then told that he was cured and could marry, which he did. Two years afterward there appeared pains in his bones and muscles, headaches, and, above all, acute pain in the back of the neck. The patient did not fail to inform his physicians that he had had syphilis, but they could find no trace of that disease, and told him that

he was suffering from neuralgia. He took iodide and was treated by hydrotherapy without avail. The headaches had lasted for about eight months, and the muscular pains had so to speak, never ceased. For five or six years he had experienced severe intercostal pain, and the testicle had again become large and hard.

"I could, therefore," says M. Rocheblave, "no longer have the least doubt that the case was one of old syphilis, perhaps well treated by chance by potassium iodide, but certainly badly treated by mercury, because in twenty-five years the treatment had been given but for thirty-eight days, and terminating exceptionally in a general manifestation, fever, instead of, according to the usual rule, a sclero-gummy lesion. This fever, rebellious to 61 grammes (nearly an ounce) of quinine, could be conquered only by mercury, and in order to have the testimony of treatment by virtue of the old adage, *curationes naturam morborum demonstrant*, the writer prescribed only the protiodide in the dose of 0.10 gramme (1.5 grains) instead of the mixed treatment.

By the end of the second day the appetite and strength rapidly returned, and, fifteen days afterward, the patient, who had several times been condemned, was able to resume, in an effective manner, the direction of his affairs.—*Le Bulletin Medical*.



CREOSOTE IN PNEUMONIA—A RESUME.*

BY I. L. VAN ZANDT, M. D., FORT WORTH, TEXAS.

January 7, 1894, on account of indications of fermentation in the alimentary canal, I gave a patient, forty-eight hours sick with pneumonia, one drop of creosote every three hours. This was added to my ordinary prescription. I was surprised, on my return the next day, to find the temperature slightly subnormal and other symptoms correspondingly improved. The dose was reduced; the temperature went up. Again I gave a larger dose, and the next day dismissed my patient.

I was so impressed by this observation that I began then, and have continued to this day, prescribing creosote in all cases of pneumonia.

In June, 1898, I read a paper on the subject before the North Texas Medical Association. This was received by some with incredulity, they citing the fact that "all authorities" (whatever that may mean) said that pneumonia was a self-limited disease, and must run its course. Others were willing to make a trial on my report, reinforced by that of several gentlemen present, who had adopted the treatment at my suggestion.

Quite a number of those present, and others who read the published paper, have reported satisfactory results.

In my former paper I mentioned that there was some unevenness as to results in different cases, some yielding in twenty-four to forty-eight hours, others continuing a week or more. I suggested that difference in the infecting micro-organism might account for this unevenness, favoring the idea that the pneumococcic-infected were most amenable to the treatment. This

seems to have a probable corroboration in the reports of some others, written and verbal; but the absolute corroboration can be had only when the clinician and microscopist unite in the investigation.

My original prescription was ammonium salicylate, grains seven and a half, creosote one drop, syrup one drachm, every three hours. In some cases the creosote alone was given. Latterly I have given creosote carbonate grains (or minimin) seven and a half, emulsified with acacia. Others give larger doses, with possibly better results and no harm.

During all this time I have had cases in which the fever was gone in from twenty-four to forty-eight hours, and I am now somewhat disappointed if my patient is not ready for dismissal by the third or fourth day. In cases which persist longer there is generally an amelioration of symptoms, and the coming of an appetite, to which I was formerly a stranger in pneumonic cases. There is generally a gradual decline in the fever, with only slight moisture of the skin, a critical sweat being rare.

Another thing I, as well as others, have found, is that if the medicine is discontinued as soon as the fever has ceased, there will likely be a recurrence of all the symptoms. Hence I continue the medicine at longer intervals for two or three days after subsidence of the fever.

This recurrence of the fever in lobar pneumonia is a strong argument in favor of the improvement being due to the medicine, for, according to Austin Flint, in lobar pneumonia "relapse never occurs."

The mortality of pneumonia is, as

* Read before the Central Texas Medical Association.

given by Tyson, lobar 20 to 40 per cent., lobular 30 to 50 per cent.; Osler lobar 20 to 25 per cent., lobular, 30 to 50 per cent.; Delafield, lobar 12 to 34 per cent.; Anders, lobar, 15 to 25 per cent., lobular, 25 to 50 per cent.; average of all, 22 to 39 per cent.

In these seven years I can now recall only four fatal cases of pneumonia in my practice. Two of these were under my care from the beginning of the attack; one following grippe, the other a measles case in most unsanitary surroundings. The other two patients were turned over to me in desperate condition; one sick a week, the other two weeks. In the earlier part of this time I think I lost two or three babies. I treated sixteen cases last winter with no fatality; dismissing four on the second, five on the third, one each on the fourth, fifth, sixth, seventh, eighth, and two on the tenth days.

Within a year or two after my first observations I saw that some French writer was recommending creosote for bronchopneumonia. In the fall of 1898 "The Doctor's Factotum" contained an extract from the London *Lancet*, reporting twenty-six cases of pneumonia treated with creosote, without a death, of much shorter duration, and with a better recovery than usual. Creosote was not given early in these cases.

Prof. Andrew H. Smith, of New York, in the *Medical News*, November, 1899, after citing several writers and his own experience, goes so far as to recommend that family physicians keep their patrons provided with carbonate of creosote or one of the salicylates, preferably the former as being better tolerated by the patient, so that in case of indications of an attack of pneumonia (pain in the side with chill), he may take the drug at once and probably prevent the development of an attack.

Dr. J. A. Gracey, in the *Charlotte Medical Journal*, November, 1899, says:

"The treatment of pneumonia by the administration of creosote was first brought to the notice of the writer by a paper read by Dr. Van Zandt, of Fort Worth, Tex., at a meeting of the North Texas Medical Association. . . .

My method is to give either drop doses of creosote every two hours, or minimin ten or fifteen of creosote carbonate in some simple menstruum. When given early in the attack the results are almost specific; the temperature subsides, the respiration improves, and in the course of twenty-four hours the condition of our patient is so much improved that we sometimes doubt our diagnosis.

"In later stages the results, while not so brilliant, are yet very satisfactory. The cough, pain and temperature subside, the character of the sputum is changed, and recovery is hastened. And not only in pneumonia do we get such good results, but in acute bronchitis as well.

"The method is worthy of trial, and one has only to use it to be convinced of its merits. Of course, the strength of the patient must be supported, the secretions and excretions attended to; and I am satisfied that we have in the creosote treatment as near a specific for the trouble as is known to-day.

"At the pediatric congress held in Marseilles in 1898, Dr. Cassouté, physician-in-chief to the Marseilles hospitals, gave a brief preliminary notice of his new method for the treatment of pulmonary affections. The method consists in the continuous administration of fairly large doses of creosote carbonate. In most cases a typical fall of temperature occurred during the first twenty-four hours of treatment; and if the creosote carbonate was continued for a sufficiently long period of time the apyrexia was a permanent one. The temperature curve

rose again, however, when the drug was discontinued, before the auscultatory signs had disappeared. Relapses and sequelæ, so frequently seen under other methods, were entirely absent."

Dr. Charles F. Stokes, United States navy, in the *Brooklyn Medical Journal*, August, 1900, says: "I have employed it in several cases with excellent results. . . . Early treatment offers most satisfactory results."

Dr. J. W. Frieser, of Vienna, in the *Ärztliche Central-Zeitung*, says: "The treatment of acute inflammatory affections of the respiratory passages with the drug has yielded entirely satisfactory and even brilliant results in my hands. Both clinician and practical physician are fully aware that we formerly possessed no remedy that was even half way satisfactory in its action upon pneumonic disease process. Our entire therapeutic armamentarium was symptomatic and expectant in its nature. . . . But it is an unmistakable advance if experience teaches us the employment of a remedy which has an influence on the disease process itself, and possibly upon the specific organisms that cause it. The favorable effects of creosote carbonate upon the various forms of pneumonia have been noticed by others as well as by me; and they are undoubtedly due to antiseptic and anti-bacterial action of creosote, which, in the form of the carbonate, can be introduced into the body in sufficient quantity and in innocuous shape. . . . Besides this it has a favorable influence on the heart and the patient's general condition; it causes, as I have often noticed a rapid fall of temperature and retrogression of the local symptoms. The gastro-intestinal canal is in no way injured by its use. . . . In some cases the inflammatory processes in the lungs got well with such extreme rapidity that the method might be called an abortive treatment. The temperature rapidly sank to

normal, the general condition noticeably improved, the tongue cleaned and became moist, and the appetite returned.

. . . Equally favorable results were obtained from the use of creosote in five cases of acute bronchitis. The action of the drug was reliable and the recovery of the patient rapid."

Dr. Wilhelm Meitner, in the *Medicinisch-chirurgisches Centralblatt*, June 22, 1900, says: "The most important effect of the creosote treatment is the surprising fall of temperature a few hours after its administration is begun; it becomes normal in two days or sooner. With this the general condition improves, the pulse becomes better, the breathing quieter; the cough is lessened, thirst ceases, and the dryness of the mouth and lips disappears. Then the tongue cleans, the appetite returns, the entire course of the disease is cut short, and convalescence is about abrogated. Under creosote treatment I have never seen that weakness followed by a slow convalescence, which is the rule even in typical one-week pneumonias, under the usual medication.

"Some cases run so rapid a course under the treatment that it is hardly possible to give their history. A child falls suddenly sick, with a temperature of 102.2° or more, and the pulmonary signs of an acute catarrh. After two or three doses of creosote carbonate in the next four to six hours it is better; in twenty-four hours the fever and physical signs are gone; on the second day the child cannot be kept in bed. An adult with marked coryza suddenly begins to cough violently; the first large dose of creosote mitigates his cough, and in twenty-four hours it has disappeared. To me, at all events, the favorable influence of creosote carbonate in acute pulmonary diseases seems absolutely demonstrated. I am sure that its action is the quicker the earlier its administration is begun; t F

it is harmless and well borne in the doses that I employ; and that no other treatment at all is required in the class of cases under consideration."

Dr. M. Eberson, in the *Ärtzliche Central Zeitung*, July 7, 1900, says: "It has been customary, after the diagnosis of a pneumonia has been made, to admit the presence of a severe disease, requiring five to nine days to run its course. Creosotal von Heyden is now prescribed by the attendant. When he returns on the next day there is no trace of fever. The child is playing, it is hungry, bright, and does not cough. Percussion and auscultation show no signs of inflammation. The physician, and more especially the parents, begin to have a doubt of the diagnosis. But now comes the interesting part! Treatment is stopped; and behold! on the next day the subjective and objective symptoms of pneumonia are again present."

"Two things may therefore be claimed for the creosote treatment. In the first place, it cuts short the disease in a most

remarkable manner. In the next, and more important, it causes complete resolution of the disease focus, so that the sequelæ, more especially after catarrhal pneumonia, will not be as important in the future as they have been regarded to be in the past. Nor does it seem to me to be unimportant, considering the bacillary origin of pneumonia, that the sputum and excreta are voided disinfected, so that the contagiousness is reduced to a minimum.

"It is incontestable that the creosote treatment of pneumonia is a very important advance in practical medicine."

Now with this array of testimony reinforcing my own observations for the last seven years, I trust that the members of this association will not consider me oversanguine when I express the opinion that the use of creosote or carbonate of creosote in the treatment of acute pulmonary inflammations is one of the greatest life-saving discoveries of the century just ended.



Editorial

THE MEDICAL TIMES AND REGISTER is published monthly.

All communications, reviews, etc., intended for the editor should be addressed to 367 ADAMS STREET, DORCHESTER, BOSTON, MASS.

THE MEDICAL TIMES AND REGISTER is published by The Medical Publishing Co., 1602 Arch Street, Philadelphia, Pa., to whom all remittances should be made by bank check, or postal, or express money order.

Subscription price is \$1.00 a year in advance. Foreign countries, \$1.50. Single copies, 10 cents.

Advertising rates may be had on application at the Philadelphia office.

Original articles of practical utility and length are invited from the profession. Accepted manuscripts will be paid for by a year's subscription to this journal and one hundred extra copies of the issue in which such appears if desired.

Reprints of Original Articles are not furnished except on payment of cost price by the author. Entered at the Philadelphia Postoffice as second-class mail matter.

RECENT ITEMS ON FRACTURE.

Among the latest and most valuable contributions on fracture is one from the pen of Dr. Lewis Schooler. (*) In no contribution of such brevity has the writer ever seen so many fundamental principles or practical points in therapy suggested.

The author opens in the following paragraph:

"The oldest surgical subject on record is, without doubt, fractures. They occurred before man knew more than the lower animals about the construction of his own anatomy; and he probably knew more about the adjustment of fractures and their treatment in a general way for centuries than he did about the subject of anatomy even in a general way. But with the evolution of his mental capacity came the evolution of his physical development; and with the increase of population there arose a demand for more varied pursuits and a change in environments, which have and are

continually increasing the dangers and the number of fractures in the same, or perhaps a greater, ratio than that existing between wild and domesticated animals. With this increase of the number of fractures due to our higher civilization and modern methods in agricultural and commercial pursuits, it is but natural that the literature upon this subject should be enormous. Yet only a few well-defined principles are recognized or deemed necessary for the accomplishment of desirable results, and perhaps no other mechanical principle will ever be evolved, though one or two will be emphasized, both in literature and practice, made possible by modern methods of surgical technique."

One might say that volumes are compressed into this brief introduction, as applies to closed fractures as the most revolutionary and far-reaching changes and improvements have been made in the treatment of shattered, open fracture.

"Since fractures unite by the same means as do cases of solution of con-

* 1. "The Pathology of Fractures," by Lewis Schooler, M. D., Des Moines, Ia., April 16, 1901, in "The Railway Surgeon."

tinuity of other tissues, the same rules in regard to approximation should govern, viz, the control of hemorrhage and the removal of all hopelessly damaged tissue. The removal of everything that prevents accurate coaptation of the fractured extremities, including pieces of bone, muscular, periosteal and other tissues, including blood-clots, is necessary, and, in addition, some means must be resorted to for the purpose of holding the fragments in place. This is only necessary in cases where the above-named causes exist, a class far short of a majority; therefore the necessity of cutting down upon a large proportion of simple fractures is unnecessary. In all cases, however, where doubt exists as to the ability of the surgeon to secure approximation, the rule should be to convert the simple into a compound fracture, temporarily. The ease and safety with which this can be done commends it to the intelligence of many progressive surgeons. Where this conversion is made, the method of retention will readily and at once suggest itself to the operator. The wiring together of the fragments, their retention by kangaroo tendon or heavy silk or catgut, or by a suitable retention splint or fixed dressing as is frequently done in cases of fracture of the patella, the nailing together of the pieces or the use of the clamps devised by different persons for the purpose are familiar to all."

The above embodies material for a volume. "Fractures unite without callus?" Certainly, and invariably, when non-displaced, in vigorous subjects, and if the vitality of the limb be not paralyzed by firm fixations.

Cutting down will the better enable us to perfectly adjust the fragments in some cases, but will it enable us to

safely and with advantage permanently hold the fragments in position?

Well, perfect replacement is seldom possible. Is it necessary for good functional results? The wire, nails, rivets, etc., have all been employed by myself, but, with few exceptions with regrets. They have little more than a theoretical value, in any other than very exceptional cases.

"It is beginning to be better understood that bony tissues heal, after a fracture or other injury, where accurate approximation of the fractured extremities is secured in the long bones, in precisely the same manner as do the soft tissues.

"The above statement may be verified after union is complete, as was recently done in one of my own cases of a fractured humerus with such an amount of displacement that the musculo-spinal nerve was completely severed, and the later operation was undertaken for the purpose of reuniting the severed extremities of the nerve. Repeated examinations previous to the operation failed to indicate the presence of a callus, and when the bone was exposed no trace of the line of fracture was discoverable. In many other cases in my own, as well as the practice of others, have I seen healing by first intention, and with such rapidity that without the positive evidence of our senses we would have been compelled to doubt the existence of it."

"Why the illustrations in all of the works are made to show a union with the fragments in a vicious position is unintelligible to the average student of surgical pathology, unless it be to show the capability of natural forces under unfavorable circumstances."

Primary union of broken bones is long well known and always occurs in

non-displaced fracture, in the impacted and those fractures which may be reduced and retained without bandage or splint impellent. The average text-book yet runs the same old rigmarole about "primary and permanent callus," when there is neither as a rule in any fracture.

As to the illustrations in the books, their delineations are accurate, as a displaced fracture will rarely unite with symmetry of outline. These are the cases in which the X-rays exhibit such hideous outlines and may induce the patient to at once sue his physician though he have an excellent result, as far as the use of the member goes.

"Most authors at the present time are agreed that the formation of a callus is an absolute and inevitable result in cases of union after fractures of the long bones, and nearly all the chapters in textbooks are illustrated for the purpose of impressing this idea upon the minds of students. To my mind this illustrates very forcibly the tendency of our ablest men to not only bow to authority, but an unwillingness to even scrutinize the premises upon which these teachings are based. In many instances they utterly ignore the plain lessons of observation, though oft repeated, even in the face of the fact that the profession is always looking forward instead of backward. This may be partly accounted for, perhaps, upon the ground of legal responsibility. The final arbitrament of all causes of complaint lies in those who have the greatest respect for the opinions of deceased chancellors and judges, and who never allow themselves to look in any direction, except backward."

The authors, we fear, were drawing on their imagination. In obedience to custom they compiled and

wrote their books first, and learned something about fractures after. Most men when their harvest is gathered, rest on their oars in their declining years, and are loath to enter the drudgery of book building. Men write for fame and its reward; those who are born with a pile may have the largest opportunities for study and observation, in their hospital appointments, but they pass away sterile.

"That any experienced surgeon will wholly abandon the older and familiar methods, to which he has been accustomed, for the new one with its already known defects, is not among the possibilities. There is also the probable danger that young men trained in modern hospitals with access to the Roentgen apparatus will be taught to make use of it to the exclusion of other means that have served ourselves."

The above is a most timely comment on an aid of some use, but lately extolled away beyond its merits, as a means in diagnosis or a help in treatment.

No single instance has ever been under the writer's observation in which this device has in any manner whatever elucidated fracture. It is one of the fads of the time, which in fractures will soon vanish.

"The underlying principles of treatment in all cases should be complete reduction and maintenance of the same. The keeping of the bones in the same position they occupied before the injury is aiding nature to the extent of our utmost ability and will give the best results."

The above is a hackneyed phrase which means anything or nothing.

The *perfect* reduction of a shattered bone is out of the question, moreover, if the fracture be non-displaced, a very

common type, there is nothing to "reduce."

Maintenance of reduction is mechanically possible in any fracture; but is often impracticable, or serves as a means of favoring gangrene, delaying union or favoring non-union. It has imperilled many a limb, stiffened the joints into a permanent ankylosis or left defective members.

"The views entertained by some recent writers upon this subject seem to indicate that fractures, when practically left alone, do better than when immobilized. This view is wholly untenable, for the reason that when the surgeon has failed to recognize the existence of a fracture and treats it as a sprain or contusion, employing very similar methods to those advocated by the masseurs, suits at law usually follow, and an examination reveals a faulty union, if indeed any exists. Two cases of this kind have very recently come under my observation, one with the union and deformity, the other with the non-union; the latter being in a young man, where we expect to find nature more nearly equal to the overcoming of the obstacles usually present."

The doctor pronounces the non-splint treatment as "untenable;" this

must certainly be based on inadequate observation of fracture cases. In non-displaced or impacted fracture, there certainly is nothing to splice, though it is often well to support the joints for a time.

Are we to understand that in blind obedience to authority, or antiquated "principles" we must call for a splint every time we discover a fracture?

Certainly not, and I am sure that Dr. Schooler does not intend that we should; nor should we, because union was delayed in one case or deflection occurred in another, deviate from the new methods as these results may occur after any mode of treatment.

M. Lucas Championniere, the apostle of this *régime* in fracture-therapy, recommends the splint in all displaced fractures, or those near the articulations.

Our patients should be taught that there are various types of fractures, some of which do well, do vastly better, if the limb be left unhampered.

For more than ten years the writer has practiced and taught this line and never to the detriment of his patients.

In order to be fully appreciated the reader should examine for himself the full text of Dr. Schooler's able article on this ever green subject. T.H.M.

MUST DOCTORS ANSWER CALLS?

The Indiana Supreme Court has decided that the physician is not obliged to answer a call if he feels disposed to decline. The ruling has awakened widespread discussion in medical circles, and among laymen who feel that the doctor's profession is a quasi-public one, requiring an answer to a summons regardless of inclination.

Apparently most of the doctors favor the ruling of the Indiana Court. They

declare that they are not public servants, any more than are lawyers or other professional men, and that answering a call is a matter to be decided by the physician. Doctors are human, they say, and if answering every call were made obligatory, nearly every physician would soon be worn out.

It would appear, however, that there is a fine point in humanitarianism involved, which cannot be overlooked by

the physicians, no matter how independent they may consider themselves. In cases where quick attendance is a necessity, and where there is a question of life or death involved, no physician can well refuse to respond, no matter what the inconvenience involved.

The Court has held that the physician is not legally responsible if he does not attend in such a case, but the moral side of the question is something that cannot be overlooked.

To the credit of the medical profession, it is to be said that there are few cases on record where attendance has been refused when the physician was convinced

of the genuineness of the emergency call. Consequently, as long as most calls are answered voluntarily, there would seem no occasion for the law to compel the physician to do more.

A TRAGIC DEATH.

It has transpired that a mechanic was locked in one of the ballast compartments of the steamship *St. Paul* when she was launched five years ago. The skeleton has just been found in the hull of the vessel, which is undergoing repairs.

BOOK REVIEW

"The Hospitals of Japan," by Edward C. Register, M. D., Charlotte, N. C.

This little pamphlet on "The Hospitals of Japan," by Dr. Register, who has been on a trip around the world, is a reprint from the *Charlotte Medical Journal*, of which he is the editor. The text is very interesting. It seems that while hospitals in that country are quite a rarity those that exist are fitted with every modern convenience and improvement in way of surgical and medical paraphernalia.

He describes the Japanese physician as one who delights to delve for small things rather than great ones, and he will employ days and even months over one single little thing.

"Self Examinations for Medical Students," P. Blakiston's Sons & Co., 1012 Walnut street, Philadelphia, Publishers. Price 10 cents.

This little book has been prepared by a medical man, a teacher and a writer of experience, with special reference to the actual wants of the medical student. By its help the student can successfully quiz himself on all the important branches, or review any one subject in which he feels himself to be particularly deficient.

As a rule the questions have been selected with regard to their bearing upon practical medicine, and are those most likely to be asked in the quiz-class or examination room; at the same time there are, throughout the book, many unusual ones, thus giving the student a wide range of thought, and making him generally conversant with all points connected with the matter in hand.

The modest price and practical useful-

ness of this little volume will appeal to every medical student or those expecting to undergo the trying ordeals of State Board examinations.

CONSERVATIVE GYNECOLOGY AND ELECTRO-THERAPEUTICS.—A practical treatise on the diseases of women and their treatment by electricity. By G. Betton Massey, M. D. Published by The F. A. Davis Company, Philadelphia, Pa. Price \$3.50.

This is the third edition revised, rewritten and greatly enlarged of this valuable work. The illustrations are works of art and the full-page half-tone plates of photographs taken from nature, and the numerous engravings illustrate the text and increase greatly the value and practical use of the work.

The third edition of this work indicates something of its popularity and value to the medical profession.

In the first form it was really a handbook on the use of electricity in fibroid tumors and certain other affections, and the field was so enlarged and the applications of electricity so numerous that the work has grown into a medical treatise on the medical and surgical diseases of women, with special reference to the therapeutic use of electricity. Certain ordinarily overlooked and neglected facts as to the origin and nature of inflammatory diseases of the uterus and adnexa are brought out with new emphasis and neural disorders among women are presented in a new form and the treatment for the same indicated.

This treatise does not pretend to cover the whole field of abdominal and pelvic surgery, but it does present that phase of

treatment which is of most value to the average physician and his patients. The great advantage of this work over many others, is its practical and utilitarian treatments of women's diseases. It is based on experience "which is the best teacher."

The comprehensiveness of the work can be seen from the chapter titles.

I. The Nature and Predisposing Causes of the More Common Affections of Woman.

II. On the Examination of Cases with Reference to the Propriety of Employing Conservative Methods of Treatment.

III. Introductory Remarks on Electricity as a Remedy in Gynecology.

IV. Phenomena Attending the Transmission of Galvanic Currents through Living Organs.

V. Typical Methods of Applying Electric Currents in the Diseases of Women.

VI. Additional Systematic Methods in Gynecic Practice.

VII. Menstrual Derangements.

VIII. Catarrhal Affections of the Utero-Tubal Mucus Tract and Their Consequences.

IX. Chronic Inflammatory Affections of the Ovaries.

X. Fibroid Tumors.

XI. Displacements and Non-traumatic Relations of the Pelvic Viscera.

XII. Relaxation and Functional Incapacity of the Abdominal Walls and Viscera.

XIII. The Border Line Between Gynecology and Neurology.

XIV. Neurasthenia and Nervous Prostration.

XV. Institutional Treatment.

XVI. Maternal Sterility and Impotence.

XVII. Ectopic Gestation and Obstetrics.

XVIII. Malignant Growths.

XIX. Benign Tumors of the Breast.

XX. Diseases of the Urethra, Bladder,

Rectum and Sigmoid Flexure.

XXI. The Cosmetic Applications of Electricity.

The following seven chapters deal specifically with the "Rudiments of Medical Electricity." The appendices present tables of cases treated and the results. There is a good index to the work. This work ought to be in every physician's library.

THE INTERNATIONAL MEDICAL ANNUAL,

a year book of treatment and Practitioner's index, 1901—(Nineteenth year). E. B. Treat and Co. 241 West 23d St. New York, N. Y., Publishers. Price \$3.00

The Medical Almanac of 1901, like its predecessors, gives the resume of the previous year's work and advancement in medicine, therapeutics and surgery.

It has followed the lines which have met with the approval of its readers of former editions.

In the department of Therapeutics there is added a special article on Toxins and Antitoxins, the conjoint work of Professor McFarland, of Philadelphia, and Dr William Murrell, and the latter also contributes a special article on the "Light" Treatment.

In the Dictionary of New Treatment are found articles covering the whole range of medicine and surgery, contributed by authors whose names are familiar to the Medical profession every where.

Amongst the new contributors will be found the name of Professor Ruata, of the University of Perugia, Italy, whose contribution on Tuberculosis is of great practical value. It may be of interest to know that this article was written in English by the author, and is not a translation.

Special articles on X-Ray Work in Medicine and Surgery have been written by Dr. Macintyre, of Glasgow; on

Colour Blindness, by Dr. Edridge-Green; and on Dental and Oral Surgery, by Mr. Turner, F. R. C. S.

No effort has been spared to make this volume a faithful reflex of present views, and undoubtedly it will prove of no less practical value than its predecessors.

JOHN L. STODDARD'S LECTURES.

Illustrated, complete in ten volumes. Vol. III. Balch Bros. Co., Boston, Publishers, 1899. Price \$22 to \$36 per set.

In this volume Japan is the subject of two lectures and China of one.

It is of particular interest at the present time in that it is so accurately descriptive of the country, and customs of these two countries. Mr. Stoddard first describes his journey across our own country, and the boats of the Pacific and their thirteen day voyages. Then he describes the methods of travel in Japan or the "Man power carriage."

Yokohama is picturesquely described with many valuable illustrations. The cemeteries are particularly interesting and the landscape gardening. Various descriptions of the statues, of Buddha and the Sacred Pagodas are given; all exceedingly interesting. The Japanese physician is a feature of the book as well as the masseur. Much interest is centered

in the tea houses and their quota of maid servants.

China is the subject of the last lecture in this volume and is graphically described from its eminent statesmen to its humblest servant, and from its unique cities to the great wall. In extent it is twice as large as the United States and contains many more inhabitants than several countries put together.

The Chinese doctor is interesting; there are two classes of him, the "Outside" doctor and the "Inside" one. The outside man diagnoses disease only by feeling the pulse of the patient, thrust through a screen. A favorite remedy is pulverized grasshoppers. A cure for fever is a soup of scorpions. Dysentery is treated by running a needle through the tongue. The flesh of rats is supposed to make the hair grow. Dried lizards are used for "that tired feeling" and certain diseases are only curable by a decoction whose chief ingredient is a piece of flesh cut from the thigh or arm of a son or daughter to supply which is thought to be a proof of the noblest filial devotion. In Chinese theology it is comforting to learn that there is a special place in hell assigned to ignorant physicians and the Chinese quack is boiled in oil. Chinese pay their physicians so long as they remain well but when ill the doctor's salary ceases until recovery.



OPHTHALMOLOGY

In charge of J. A. TENNEY, M.D., Boston.

Dr. Hinshelwood, of Glasgow, reports (Oph. Review) that euphthalmin in five per cent. solution takes twenty to thirty minutes to dilate the pupil, while homatropin takes only fifteen to twenty minutes. Suegiroff, of Moscow, found that all fluids are more readily diffused into the anterior chamber if a solution of holocain is first instilled into the conjunctiva sac, increasing the effect of euphthalmin up to that of homatropin. The mydriasis passes off in two or three hours, so the pupil reacts to light and accommodation. The accommodation is affected by the drug, but only to a slight extent. It is valuable in making a diagnosis where iritis is suspected.

A. von Hippel, of Halle, W. Uhthoff, of Breslau, and E. Pflueger, of Bern (Oph. Review), each describe a case of partial congenital blindness, with the following similar symptoms, viz.: diminished visual acuity, a feeling of dazzling and nystagmus. The light sense is equal to the normal eye centrally; in the periphery distinctly greater. The red end of the spectrum is shortened, and its brightest part is the green.

Sattler extracts the lens, after Adolph Weber, in high myopia, without dissection, and considers the result more satisfactory, as the convalescence is shortened, the healing more uncomplicated, and the number of operations diminished. He uses the hollow lens, the sharp hook, and a small bent wire loop. The lens is separated from the anterior and posterior capsule by the sharp hook, and is extracted by pressure or by scoops.

K. Baas, of Freiburg (Oph. Review), believes that phlyctenular keratitis is due to disease in the corneal tissue, and not to a coccus. It commences by a lesion on the inner surface of Bowman's membrane, which is invaded by round cells. The epithelium is invaded later, and the ulcer produced.

M. Vian (Toulon) reports a case of purulent ophthalmia in an adult cured in ten days by the application of one to ten solutions of permanganate of potassium twice daily for six days, with hot poultices every two hours, and not boric lotion. After the sixth day the permanganate was used only once a day.

M. Trantas has treated night blindness successfully in ten cases by giving 200 grammes of cooked sheep's liver daily. Hippocrates treated the disease with ox liver in large quantities.

M. Kalt reports an improvement of vision in conical cornea from one-tenth to one-third, by paring the edges of the lids and suturing, so as to keep up constant pressure upon the eye.

M. Zanotti (Vercelli) reports a case, a man aged 38, who swallowed three drachms of quinine sulphate. He lost consciousness thirty minutes later, and had convulsions until the next morning, when consciousness returned, and had sensation of "brilliant lightning and deafening thunder." A little later in the morning vision was completely lost. Marked prostration followed. Hearing was abolished on the right side, and much diminished on the left. After nine or ten days the vision slowly returned, so that in two months his

acuity was one-fourth. He was blind to green, and distinguished other colors with difficulty. He had night blindness, white spots existed around the disc, and the arteries were filiform. One year later vision was three-fifths. The visual field did not extend beyond thirty degrees, the white spots around the disc persisted, and also the filiform condition of the arteries. Twelve grains in another case produced diminished vision, paleness of the disc, and contraction of the retinal vessels.

Dr. J. E. Courtney (Med. Record) calls attention to the variation in the size of the pupils after death. He says that when people die of a large cerebral hemorrhage, the pupils are large on the side opposite the lesion, and remain so ten or twelve hours after death. In cases of death from parietic dementia, with a general meningocerebritis, the pin-point pupils were unchanged at the autopsy. In cases of pachymeningitis hemorrhagica, the contracted pupil on the side of the hemorrhage also remained unchanged.

The *New York Medical Journal* editorially states that one of the prominent railway lines has decreed that hereafter tobacco users shall be barred from its employ in certain capacities, because of the danger of the induction of color blindness. The editor further

states that eighty per cent. of artists use tobacco, and asks if perception of color is not essential to the artist?

WESTERN OPHTHALMOLOGIC
AND OTO-LARYNGOLOGIC
ASSOCIATION.

APRIL 23, 1901.

DEAR SIRS.—Please note in your esteemed journal that the following officers were elected at the sixth annual meeting of the Western Ophthalmologic and Oto-Laryngologic Association, held in Cincinnati April 11th and 12th:

Dr. C. R. Holmes, Cincinnati, O.,
President.

Dr. W. L. Dayton, Lincoln, Neb.,
First Vice President.

Dr. J. O. Stillson, Indianapolis, Ind.,
Second Vice President.

Dr. H. W. Loeb, St. Louis, Mo.,
Third Vice President.

Dr. O. J. Stein, 100 State street, Chicago, Treasurer.

Dr. William L. Ballenger, 100 State street, Chicago, Secretary.

At the meeting in Cincinnati the scientific programme was of very high grade. Forty new members were elected.

The next meeting will be held in Chicago, April 10th, 11th and 12th, 1902.

WILLIAM L. BALLENGER, Secretary.

CLINICAL SURGERY AND SURGICAL PATHOLOGY.

In Charge of T. H. MANLEY, M. D., New York.

TOTAL EXTIRPATION OF THE LARYNX.

BY DR. R. V. HIPPEL, DRESDEN.

(Arch. Fur. Klinische Chirurgie, 62 vol. p. 180.)

During the past ten years the operation for total extirpation of the larynx has been received with more favor than formerly and no other operation of its importance, which has been so improved by antiseptis and asepsis has been so little mentioned. According to Taube the former mortality was 41 per cent., now the average is 10 per cent.

The reasons for this difference are not hard to find; not the infective operation and the long period of time consumed in operating, but rather the technique in operating.

By the former methods a vast deep opening was made, the parts and the wide open trachea left open for the absorption of septic microbes, infectious pneumonia following, or deep-seated suppuration of the mediastinal glands. These rather than the operation itself were the cause of death.

The writer proceeds and describes the mode of operative procedure which gives the best results. He recommends the Trendelenburg position with Rose's depressed head-support, then a preliminary tracheotomy is made under cocaineization. The pharynx is firmly tumpounded.

After division of the integument and the deep cervical fascia, the thyrohyoid membrane is divided and the larynx opened in the middle. The

larynx removed after the method of Bardenheuer, the wound in the pharynx is sutured.

The detached tracheal stump is now securely fixed in the wound by deep sutures and a well tamponed canula left in situ.

He cites Foedel as declaring that when the divided end of the trachea is anchored by the primary circular suture we need have little fear of a narrowing of this aperture from cicatrizing of the wound.

NOTE.—Laryngectomy, partial or complete, is one of our modern radical operations for neoplasms involving the laryngeal mucosum and deeper parts. Theoretically it would strike one as an operation not infrequently called for, and moreover, because of the comparatively superficial situation of the larynx in the neck it would seem to be a procedure devoid of any great mechanical difficulty in execution. But, when we closely study the structures and functions we realize the difficulties in the way. We note that the larynx is concerned in three important functions: in respiration, phonation and deglutition, that the whole respiratory apparatus in the neck is suspended by a MUSCLE passing down from the lower jaw, the base of the skull and the hyoid bone, and hence when the larynx is completely detached from the trachea the latter tends to sink deeply into the thorax.

Descriptive anatomy fails to give us a correct idea of the enormous vascular supply of the superincumbent

areas of the larynx when invaded by neoplasia, hence why in enucleation the escape of blood is large and difficult to control.

The diagnosis between syphilitic, tubercular and epithelial ulceration and infiltration is by no means simple here.

I had a case coming under my care some years ago, in a young woman who had an ulcerated larynx. Her general condition and the history of the case pointed to tuberculosis, but a specialist pronounced it sarcomatous. After a horribly sanguinous operation the larynx was removed.

As the tissues were so highly vascular, the sutures had to be re-inforced by 20 hæmostatic forceps. After operation, her appearance and agoay were pitiable in the extreme, and death came to her relief in 20 hours.

Shortly after this painful *denouement* a middle aged physician came to me for advice for a laryngeal ulcer, with evidence of tubercular trouble in the lungs.

He had been informed after a snipping of the indurated mucosum had been removed and examined under the microscope, that he had a "cancer" and that his only hope lay in immediate operation. He was advised by me not to consent to any such a mutilation. Under local and general treatment he made a good recovery from his throat affection, and now after a lapse of five years, is in the enjoyment of fair health and actively engaged in his professional duties.

The writer is familiar with no procedure in the whole range of operative surgery so rarely warranted as a laryngectomy, for the reasons, that it is at once an operation with a large mortality; in malignant disease it may arrest but it cannot *cure* it; nor can any thing else.

Tracheotomy, at once a safe and simple procedure, under cocainization,

will accomplish all and more, than radical surgery here. It entails the perpetual wearing of a tracheal canula, and so does extirpation.

By the employment of local remedies, lavage and antiseptic solutions, very much comfort may be secured, until the disease, if malignant, generalizes and destroys life.

It may, perhaps, not be generally known that stenosis of the larynx in malignant disease seldom occurs to such a degree as to render tracheotomy imperative. This is resorted to rather for the purpose of giving rest to the parts and permitting of more effective local measures. Of all the afflictions that seize on humanity this is the most distressing; but it is a condition, thanks to discoverers of new remedies, made tolerable in our time by euthanistic resources, by opium, cocaine and alcoholics.

Let us, however, in all cases test and exhaust specifics and general medication before we brand them "malignant."

T. H. M.

THE USE OF MORPHINE IN SURGICAL PRACTICE.

BY EDWARD MARTIN, M. D.,
Professor of Clinical Surgery, University of Pennsylvania.

Partly because of a distrust of all drugs, partly because of the teachings of the laparotomists, morphine is generally regarded by the surgeon as a medicament to be administered only under most exceptional circumstances. Because of its at one time indiscriminate and too free use, the immediate ill effects of this drug have been put forward so prominently that its employment is regarded as a choice of evil at best, as utterly unjustifiable under ordinary circumstances. The chief objections urged against it are: (1)

It masks symptoms ; (2) it checks secretions and elimination ; (3) it causes nausea, vomiting and constipation ; (4) it depresses the vital centres ; (5) the morphine habit is easily formed and is difficult to break.

The value of the drug lies in the fact that it quite certainly relieves pain, and in many patients makes anesthetization much easier.

Were the evil effects above enumerated constantly or even commonly appreciable, its use should rightly be restricted to cases of its absolute need. As a matter of observation for ten years in three hospital services, when morphine has been administered because of the indications shortly to be given, its effect has been beneficial without qualification, and often, though not always, in people who ordinarily exhibit an idiosyncrasy against the drug, most commonly manifested by nausea and vomiting. When the indications for its use were present I have not hesitated to use it after all operations, including those on the kidneys or intestines.

The drug should always be given hypodermically, since thus it exerts its minimum effect on the stomach and bowels. The indications for its use are :

1. Shock with pain and restlessness.
2. Before operation, uncontrollable nervousness, a history of previous difficult etherization, or alcoholism. Fifteen minutes before administering the anesthetic, from an eighth to a quarter of a grain of morphine may be given hypodermically.
3. After operation, pain so harassing as to cause restlessness.

The much greater ease with which a drunkard or wildly nervous patient is etherized after having taken morphine, is so generally known that the rarity with which this drug is used

under such circumstances shows how profoundly the profession has been prejudiced against it. Not only is the anesthetic taken in less quantity and more quickly, but the subsequent struggling and vomiting are also modified ; nor during the twenty-four hours succeeding the hypodermic injection can any of the injurious effects of morphine be noted.

In the tossing, wearing restlessness which often characterizes severe shock and hemorrhage, whether pain be present or not, the immediate injection of a moderate dose of morphine while preparation is made for hypodermoclysis or intravenous injection is followed not only by rest, but by an improvement in all the threatening symptoms. This injection should be repeated at fifteen minute intervals until the desired effect—rest and relief of pain (when this is present)—is produced. Under such circumstances both body and mind are splinted the patient's apprehension of terror is relieved, he is saved the exhaustion incident to his constant motion, his heart action becomes more quiet and regular, and he is put in the best possible condition for the favorable action of restorative measures. Because of this quieting action on the heart morphine is, I believe, our best internal hemostatic.

Following many operations when the patient recovers from ether, he suffers more or less pain. When this is moderate in degree, gradually eases from hour to hour, and is well borne, it does little harm ; when it is so intense as to produce restlessness, the patient constantly turning or wishing to turn, and incessantly moving the arms and legs, it should be relieved by morphine, and this quite regardless of the region or organs operated on. In more than a hundred cases I have

given it for the relief of pain and restlessness following intraperitoneal operations, and in not a single instance were its effects other than beneficial. It has not rendered the subsequent opening of the bowels more difficult ; it has quieted violent peristalsis, which works only for ill ; it has slowed, steadied and strengthened the heart ; and has given rest to the body and mind.

With all due respect to the admirable work done by the gynecologists, I believe they have carried beyond the bounds of reason their crusade against morphine. When preceding operation the gut has been emptied by appropriate diet, by laxatives, and enemata, and has been treated by the mouth administration of intestinal antiseptics, and when the operation has been neat, cleanly, and completed without rough handling or infection, an immediate subsequent active purgation would seem as little called for as would the violent kneading of the inguinal region after an operation for the radical cure of hernia. Under other circumstances I freely admit the value of the saline treatment ; it is rather against its indiscriminate use that I would protest. Thus I have seen an unfortunate woman, whose ureter had been accidentally ligated by her surgeon, take almost with her last breath her eighteenth futile dose of salts for the relief of an anguish greater than that caused by the cunningest device of the most fiendish inquisitor. In this case absolute dependence upon a measure often successful was quite as misleading to the surgeon as would have been a masking of the symptoms with morphine. And as opposed to the argument against the use of the drug—*i. e.*, the masking of symptoms—it may be said that pain is perhaps the least important and reliable single

symptom of serious intraperitoneal trouble. Abdominal rigidity, true obstructive symptoms, pulse, respiration and temperature, are but little masked by morphine.

Following nephrectomies] and nephrorraphies the pain is likely to be particularly severe, and under such circumstances I have never hesitated to give morphine, though it is commonly believed that this drug markedly affects the kidney secretion.

The general indications as to the employment of morphine in surgery may be summarized as follows :

1. Morphine should be given hypodermically and in doses sufficient to accomplish the purpose for which it is given.

2. When surgical shock is attended by such severe pain as to cause uncontrollable restlessness, morphine should be given in doses adequate to relieve it. The same treatment is indicated for shock restlessness without pain (usually due to hemorrhage) ; the appropriate general treatment for shock being also carried out.

3. Morphine is the best internal hemostatic in the treatment of hemorrhage. When the hemorrhage is complicated by restlessness morphine is absolutely indicated, because of its quieting effect upon both mind and body.

4. When drunkards, or exceptionally neurotic patients are to be anesthetized, a preliminary hypodermic injection of morphine renders such anesthetization quicker, easier and safer, and favorably affects the stage of recovery. Obstinate and exhausting vomiting after ether is sometimes relieved by morphine.

5. If in the first twenty-four hours after operation pain becomes so severe as to cause uncontrollable restlessness, this should be relieved by morphine.

To this rule there are practically no exceptions; it applies to all operations regardless of the operative area.

6. When used in accordance with these indications, the beneficial effects of morphine so overshadow its injurious effects that the latter are not demonstrable. To this rule there may be a very few exceptions.—*The Indian Lancet*, February 11, 1901.

SPINAL COCAINIZATION AND MENTAL SHOCK.

The latest pronouncement on the subject of spinal cocaineization comes from Dr. Maurice H. Richardson, of Boston (*Boston Med. and Surg. Jour.*, January 10), and is inspired by a visit he made last August to Tuffier's clinic in Paris. The value of Dr. Richardson's judgment on surgical subjects will be disputed by none, and his unusually good opportunity to witness this new method in a clinic where it is used so skillfully, gives his judgment all the more interest and importance. Dr. Richardson, in brief, saw two major abdominal operations performed on patients who were lying with almost imperceptible pulses, blanched faces, and perfectly conscious minds. One of these operations was for the removal of two ovarian cysts, and the other for a large renal tumor. The skill with which the operations were performed was brilliant and remarkable, and the impression made upon the minds of the group of American surgeons present was altogether favorable so far as the operator and his technic were concerned; but the impression

made on Dr. Richardson's mind by the ghastly and even alarming condition of the patient was distinctly unfavorable to this method of anesthesia. The condition, as described, was not unlike surgical shock. The pulse was almost imperceptible, but not greatly accelerated; the face was blanched, and the patient, perfectly conscious, said repeatedly that she felt no pain. How much of this condition was due to the cocaine, and how much to the overwhelming mental impression, is uncertain, but we are strongly inclined to believe, after reading Dr. Richardson's graphic description, that the state of mental shock, caused by the patient's full consciousness of the horror of the whole surgical procedure, was the vitally important fact. What permanent, or even lingering effect, this shock may have upon a patient is, of course, as yet a mere speculative subject, and one which surgeons, who usually see little of their patients long after an operation may not deem important, but are glad that a surgeon himself, like Dr. Richardson, has recognized this dreadful mental state, and has appreciated it fully and described it accurately. To our mind it furnishes one of the strongest arguments against spinal anesthesia, for we believe that few patients, and especially few women, are so constituted in their nerves that they can lie fully awake and see their abdomens opened and evacuated of tumors, without receiving a mental shock which may be most disastrous in its far-reaching effects.—*The Philadelphia Medical Journal*.

THERAPEUTICS

 In charge of H. B. SHEFFIELD, M. D., New York.

USE OF OBSTETRIC FORCEPS.

For a delay in the second stage of labor, arising from (a) uterine inertia, (b) small-size vagina, (c) rigidity of maternal tissues, (d) obstruction from bands, (e) large size of head, (f) want of flexion, (g) pelvic deformity. For delay in first stage, (rarely) as in (a) placenta prævia, (b) rigidity of the os-uteri, (c) absence of a natural dilating agent. For certain accidents in labor in any stage, and when rapid delivery is indicated, as (a) convulsions, (b) prolapse of funis, (c) excessive uterine action, menacing rupture. For certain secondary purposes, as (a) extraction of the child after rupture of the uterus, (b) for removing tumors and foreign bodies from the maternal passages.—DR. W. J. GILLETTE, *The American Medical Compend*, November.

AQUEOUS EXTRACT OF SUPRARENAL GLANDS.

I have used it with excellent results in the treatments of oncoming and existing tonsillitis in all four tonsils, from the simplest congestion to the most severe quinsy, and even in diphtheria. The spraying of the suprarenal upon the congested and swollen tissues not only reduces the congestion for the time being, but causes the whole organ to seem to the patients less swollen. They speak immediately of increase of space in the throat, and are able, especially in the severe quinsy cases in conjunction with a little cocaine, to get down some sadly needed nourishment.—DR. HENRY L. SWAIN, *Yale Medical Journal*, November, 1900.

A NEW TREATMENT FOR TUBERCULOSIS.

For the past two and a-half years, O. A. Fliesburg has used the following formula: R Iodi puri cryst., 1.50; phosphori puri, 0.25; thymolis, mentholis, each 2.50; guaiacolis, 1.25; ol. morrhuae sterilisat., 50.00. Ft. sol. secundum artem. Sig.: Use only hypodermically. For tuberculosis of the lungs, throat, glands, and intestines, one to three syringefuls once a day, preferably in the forenoon; for tuberculosis of joints and tendons inject into foci deeply, and then apply bandage; repeat in four to eight days as necessary. The injection, if made deeply into the muscles, is not painful, and causes hardly any erythema or induration. If these occur at all, they always disappear in from forty-eight to seventy-two hours, without suppuration. There is sometimes at the beginning of treatment a slight fever of one or two degrees F. The injections should never be made in the same place twice in succession. — *Northwestern Lancet*, March 15, 1901.

TREATMENT OF SOME SEPTIC CONDITIONS.

To Professor Crede belongs the credit of having shown that in metallic silver in the colloid form, we possess an agent which not only destroys pathogenic organisms, but renders their toxins inert and harmless. In an article recently published in the *Medical Summary*, Dr. Max Staller, Surgeon to Mt. Sinai Hospital, Philadelphia, relates his experience with the unguentum Crede, a 15 per cent. preparation of soluble silver, and this

report serves well to illustrate the wide range of utility of this remedy in affections of bacterial origin. During the past two years the author has treated 25 cases of erysipelas with unguentum Crede. The ointment was rubbed gently into the inflamed area for 20 or 25 minutes, by which time the greater portion had been absorbed. Any case, if seen early, was cured in three to five days. Improvement was noticeable within five to six hours, the skin losing its parchment like appearance, becoming softer, and the burning sensations also subsiding. A case of cellulitis phlegmonosa of the leg in a patient suffering with nephritis was cured within three days by four applications of unguentum Crede of two drachms each at intervals of five hours. In gonorrhœa at the first threatening symptoms of bubo, two or three inunctions of one-half drachm over the affected area, with rest for 24 hours, always aborted pus formation. Remarkably successful results were obtained in mammary abscess from the use of the ointment in connection with the ice bag. Even when it failed to prevent suppuration, it localized the process and completely relieved the pain and discomfort. An inunction of two drachms, repeated three times at intervals of four hours, usually prevented pus formation if the case was seen early enough. During an epidemic of cerebro-spinal fever the author employed unguentum Crede in seven cases, with only one death, each patient receiving six inunctions, besides the routine treatment. In 50 cases of scarlet fever, some of marked severity, the remedy also exerted a pronounced beneficial effect. A mixture of unguentum Crede, two drachms, to two ounces of ung. aqu. rosæ was rubbed into the body, and in none of these cases was

the least trace of albumen observed in the urine.

TREATMENT OF MOSQUITO BITES.

Dr. A. Manquat has treated numerous cases of mosquito bites with various substances, and has come to the conclusion that the most efficient applications are formaldehyde tincture of iodine, and alcohol, or eau de cologne with menthol. The solution of formaldehyde the author uses consists of Formaldehyde (40 per cent.), 1 dram; alcohol and water, of each 2 drams. As to the relative efficiency of the above-mentioned substances, formaldehyde takes the first place, but it causes considerable burning and sometimes even inflammatory reaction, and must be applied several times in succession. Tincture of iodine leaves a stain, produces desquamation of the skin and can, therefore, not be used very well on exposed portions of the body. For ordinary cases the application of alcohol or eau de cologne with menthol will, therefore, be found more satisfactory.—*Merck's Archives.*

Two years ago Dr. Rudolf Herzog, of Tübingen, undertook excavations in the island of Cos with the view of finding the temple of Æsculapius. At a depth of eighty centimetres (thirty-two inches) he came upon a mosaic flooring which represented Orpheus charming the wild beasts. At a depth of two and a half metres (nearly eight feet) in the neighborhood of the church of St. Anna, he found two columns, and not far from them the remains of an aqueduct and a small statue of a young man. Great importance is attached to Dr. Herzog's discovery of the supposed temple of Æsculapius. The excavations are still in progress, and it is hoped that many antiquities will be found.—*Med. Age.*

MEDICAL SOCIETY OF THE MISSOURI VALLEY.—The semi-annual meeting of this society was held in Omaha, March 21st under the presidency of Dr. V. L. Treynor, of Council Bluffs. After disposing of fifteen interesting papers, the members repaired to the banquet hall of the Paxton and there regaled the inner man. Stimulated by the delicate viands and Allouez sparkling water, the flow of wit and humor was continuous throughout the evening. Dr. D. C. Bryant acted as toastmaster, introducing the following speakers: "Preventive Medicine and Politicians," Dr. V. L. Treynor; "How We do it in Missouri," Dr. Chas. Wood Fassett; "The Physician Himself," Dr. W. O. Bridges; "A Specialist's Opinion on Too Much Talking," Dr. Donald Macrae, Jr. The next (annual) meeting of the Society will be held in St. Joseph, September 19th, after which the members will be tendered a complimentary outing to Eureka Springs, Arkansas.

CHANGES IN THE MEDICAL CORPS OF THE NAVY.

Week ending April 13, 1901.

Medical Director W. K. Scofield, detached from special duty at Philadelphia, April 27th, and ordered home to wait orders.

Medical Director W. C. Farwell, detached from the Philadelphia Navy Yard, and ordered to duty in Philadelphia, special.

Surgeon C. Biddle, ordered to the Philadelphia Navy Yard, April 27th, as relief of Dr. Farwell.

Surgeon S. H. Griffith, ordered to duty at the Pan-American Exposition, Buffalo, April 25, in charge of exhibit of Bureau of Medicine and Surgery, Navy Department.

Asst. Surgeon R. B. Williams, detached from Pensacola Navy Yard, and ordered

to Key West, Naval Station with temporary duty at Dry Tortugas.

Medical Inspector J. R. Waggener, detached from Naval Hospital, Cavite and ordered to Mare Island Hospital, having been condemned by a medical board of survey.

CHANGES IN THE MEDICAL CORPS OF THE NAVY.

Week ending April 20, 1901.

P. A. Surgeon N. J. Backwood, detached from Naval Hospital, Philadelphia, April 17, and ordered to the Alliance.

P. A. Surgeon L. Morris, detached from the Naval Academy and ordered to Naval Hospital, Philadelphia, April 17th.

Asst. Surgeon R. E. Peck, ordered to Pensacola, April 25.

Surgeon J. F. Ure, detached from the Dolphin, April 20, and ordered to Marine Recruiting Rendezvous, Boston.

Surgeon E. P. Stone, detached from the Naval Dispensary, Washington, April 19, and ordered to the Dolphin.

Surgeon F. Anderson, ordered to the Naval Dispensary, Washington, D. C. April 19th.

Surgeon J. E. Gardner, detached from Marine Recruiting Rendezvous, Boston, and ordered to the Naval Hospital, Cavite, P. I. April 22.

Asst. Surgeon C. G. Smith, appointed Asst. Surgeon, April 12, 1891.

Surgeon W. F. Arnold, detached from the New Orleans and to duty at Clengapo, P. I.

P. A. Surgeon A. Alfred, ordered to duty with Marine Brigade, Cavite, P. I.

Asst. Surgeon E. H. J. Grow, detached from the Glacier and ordered to the Isla de Luzon.

Asst. Surgeon J. Stepp detached from duty with 1st Reg. Marines, Cavite, and ordered to the Castine.

Asst. Surgeon H. C. Curl, detached from Castine and to Cavite, P. I.

CHANGES IN THE MEDICAL
CORPS OF THE NAVY.*Week ended April 27, 1901.*

Assistant Surgeon J. B. Dennis, detached from the Naval Academy, and ordered to the Chesapeake, May 3d.

Assistant Surgeon C. G. Smith, ordered to the Vermont, April 25th.

Medical Inspector B. Rogers, ordered to the Brooklyn, for duty as Fleet Surgeon of the Asiatic Station.

Surgeon W. F. Arnold, detached from duty as Olongapo, P. I., and ordered to the New Orleans.

Surgeon C. F. Stokes, ordered to the Cavite Naval Station, to wait the Solace.

CHANGES IN THE MEDICAL
CORPS OF THE NAVY.*Week ended May 4, 1901.*

Assistant Surgeon B. L. Wright, ordered to the Massachusetts, May 1st.

Assistant Surgeon S. S. Rodman, detached from the Adams, May 11th, and ordered to the Alert.

Surgeon H. L. Law, retired, detached from the Recruiting Rendezvous, Buffalo, N. Y., and ordered home.

"RUDOLF VIRCHOW FUND."

To the American Medical Profession:

On October 13, 1901, *Rudolf Virchow* will be eighty years old. When he completed his seventieth year a fund was started in his honor to enable the great master to facilitate scientific research by establishing scholarships, and by encouraging special medical and biological studies. Contributions to that *Rudolf Virchow Fund* were furnished by those

in all countries interested in progressive medicine, as a homage to the man whose name is always certain to arouse admiration and enthusiasm.

In Berlin a large Committee containing amongst others the names of A. Bastian, V. Coler, A. Entenburg, B. Freankel, O. Israel, Fr. Koenig, C. Posner and W. Waldeyer has been formed to call for contributions which are to be added to the original *Rudolf Virchow Fund* so as to increase its efficiency. The Committee expresses the opinion that in no better way, and in none more agreeable to the great leader of modern medicine, can his eightieth birthday be celebrated, and ask for the sympathy and co-operation of all those engaged in the study and practice of scientific medicine all over the globe.

The undersigned have formed a sub-committee for the purpose of making the American Profession acquainted with the intentions of the Berlin Committee, and urge their colleagues to participate in honoring the very man who has done more, these fifty years, than any other to make medicine a science, and international.

Subscriptions should be sent to their secretary, who will receipt therefor.

CHARLES A. L. REED, President of the American Medical Association.

HENRY P. BOWDITCH, President of the Congress of American Physicians and Surgeons.

WILLIAM K. WELCH, Johns-Hopkins University.

ROBERT F. WEIR, President, of the New York Academy of Medicine.

A. JACOBI, 110 West 34th Street, New York, Secretary.